FA-001-J
AH-001\FA-001-H Addendum
(07\30\04)

Application for AHCCCS Health Insurance
Resource Addendum

Additional information is required in order for DES to determine your eligibility for AHCCCS Health Insurance.

1. Does anyone listed on this application own, lease, or maintain a home outside Arizona? ☐ Yes ☐ No

   If Yes, who: _____ Where: _____

2. Does anyone listed on this application own or have their name on any of the following:

   a. Bank, checking, savings, credit union accounts, retirement accounts, IRA, Keogh, 401K? ☐ Yes ☐ No

      If yes, who: _____ Total amount $ _____

   b. Stocks, bonds, money market accounts, CDs, trust funds, mutual funds? ☐ Yes ☐ No

      If yes, who: _____ Value $ _____

   c. Real property (land or buildings) anywhere? ☐ Yes ☐ No

      If yes, who: _____ Value $ _____

   d. Vehicles (cars, trucks, boats, RVs, motorcycles, etc.)? ☐ Yes ☐ No
      Indicate make, model, and year, for all vehicles: _____

      _____

      If yes, who owns: _____ How many are owned: _____

Statement of Truth: I swear under penalty of perjury that the statements made on this addendum to the Application for AHCCCS Health Insurance and any other statements that I made (or will make) during the application process are true and correct to the best of my knowledge. Photocopies I have provided (or will provide) are the same as the original document. I have read and understand all the information on the Application for AHCCCS Health Insurance, including the Cooperation, Consent to Release Information, Premium, and the Assignment of Rights to Other Benefits for Medical Care; including the warning about possible criminal prosecution and penalties for providing false information.

Signature of applicant, responsible adult, or authorized representative	Print your name (Last, First, MI)	Date	Relationship
Signature of other unmarried adult applicant	Print your name (Last, First, MI)	Date	Relationship
Signature of other unmarried adult applicant	Print your name (Last, First, MI)	Date	Relationship
Signature of Witness if signed with a mark	Print your name (Last, First, MI)	Date	Relationship

Equal Opportunity Employer/Program ♦ Under the Americans with Disabilities Act (ADA), the Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. This document is available in alternative formats by contacting your local office manager.